



**RISK MANAGEMENT FUND
MOTOR VEHICLE ACCIDENT REPORT**

STATE OF NORTH DAKOTA

SFN 51301 (Rev. 12-2001)

DEPARTMENT LOCATION CODE

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- Claim Form Requested
 Destruction Hold Notice

DRIVER RESPONSIBILITY: Complete this original report immediately after the accident and fax a copy to 701-328-2514. Mail the original report to the ND Department of Transportation, State Fleet Services, 608 East Boulevard Ave., Bismarck, ND 58505-0700, no later than 2 days after the accident. If you have any questions, please call State Fleet Services at 701-328-1472 or 701-328-1434.

AGENCY	Agency Name	District/Division
	Address	Telephone Number

TIME	Date of Accident	Day of Week	Hour	A.M. <input type="checkbox"/>
				P.M. <input type="checkbox"/>

LOCATION	Highway Number	Posted Speed Limit	Location From Nearest City	Citation Issued <input type="checkbox"/> Yes <input type="checkbox"/> No
	City	Street	At Intersection With	

TYPE	<input type="checkbox"/> Backing	<input type="checkbox"/> Snowplowing/Sanding	<input type="checkbox"/> Right Angle	<input type="checkbox"/> Rear End
	<input type="checkbox"/> Turned Over	<input type="checkbox"/> Animal	<input type="checkbox"/> Head On	<input type="checkbox"/> You Hit <input type="checkbox"/> You Were Hit
	<input type="checkbox"/> Fixed Object	<input type="checkbox"/> Sideswipe	<input type="checkbox"/> Other(Describe) _____	

STATE VEHICLE No. 1	VEHICLE	Year	Make	Model	Unit Number	
	Driver's Name			Driver's License Number		
	Telephone Number - Work			Telephone Number - Home		
	Home Address			City	State	Zip Code
	Damage (List Parts)				Estimate \$	
	Passengers <input type="checkbox"/> Injured/Killed <input type="checkbox"/> Injured/Killed			Telephone Numbers Work Work		Telephone Numbers Home Home

OTHER VEHICLE No. 2	VEHICLE	Year	Make	Model	License Plate	State	
	Driver's Name			Driver's License Number			
	Telephone Number - Work			Telephone Number - Home			
	Home Address			City	State	Zip Code	
	Damage (List Parts)				Estimate \$		
	Passengers <input type="checkbox"/> Injured/Killed <input type="checkbox"/> Injured/Killed			Telephone Numbers Work Work		Telephone Numbers Home Home	

OWNER'S	Insurance Company	Policy Number
	Address	Telephone Number

DRIVER'S	Insurance Company	Policy Number
	Address	Telephone Number

WITNESS	Name	Address	City	State	Zip Code
	Location To Accident	Telephone Number Work	Telephone Number Home		

DAMAGE TO OTHER PROPERTY	What	Estimate \$	Telephone Number Work	Telephone Number Home
	Owner/Name	Address		

INJURED/ KILLED	Name				Vehicle <input type="checkbox"/> 1 <input type="checkbox"/> 2	
	Address	City	State	Zip Code	Telephone Number Work	Telephone Number Home
	Nature and Extent of Injury					

CONDITIONS	WEATHER	<input type="checkbox"/> Clear	<input type="checkbox"/> Raining	<input type="checkbox"/> Snowing	<input type="checkbox"/> Sleet	<input type="checkbox"/> Fog	<input type="checkbox"/> Other _____
	ROADWAY	<input type="checkbox"/> Dry	<input type="checkbox"/> Icy	<input type="checkbox"/> Slippery	<input type="checkbox"/> Under Repair	<input type="checkbox"/> Other _____	
	Did Vehicle Have Any Defects? _____						
	Were Seat Belts in Use? <input type="checkbox"/> Yes <input type="checkbox"/> No						
What Lights Were On? _____							

Explain How Accident Occurred

Diagram: Mark State Vehicle 1 And Other Vehicle 2

State Employee	Department	Telephone Number
State Employee Completing Report	Telephone Number	Date